28A Maitland st,
Dartmouth,NS B2Y 3L9
902-441-5175

# Health History

A complete health history helps me ensure it is safe to provide you with a massage treatment; please let me know if your status changes so I can update your form. All information given to me is confidential.

Name_________________________Email_________________________we collect your email address to send you appointment reminders. Your email address will never be shared with a third party.

Cell Phone_______________Street_______________City_____________Prov. _____Postal Code ___________

Date of Birth (MM-DD-YY)_______________How did you hear about NeuroTouch Therapy? ______________________

Do you have insurance coverage for massage? Yes ☐ No ☐ If yes, were you referred by your doctor? Yes ☐ No ☐

Insurance Carrier____________________Plan/Policy #_________________Member ID #______________________

Doctor's Name___________________________Phone_______________Last Check-Up Date ____________________

Doctor's Location______________________Unit_____City________________Prov.______Postal Code ___________

Do you see other healthcare practitioners? Chiro ☐ Physio ☐ Naturopath ☐ Osteopath ☐ Other ☐

Current Medications ______________________________

Previous Major Illnesses/Operations (include dates) ______________________

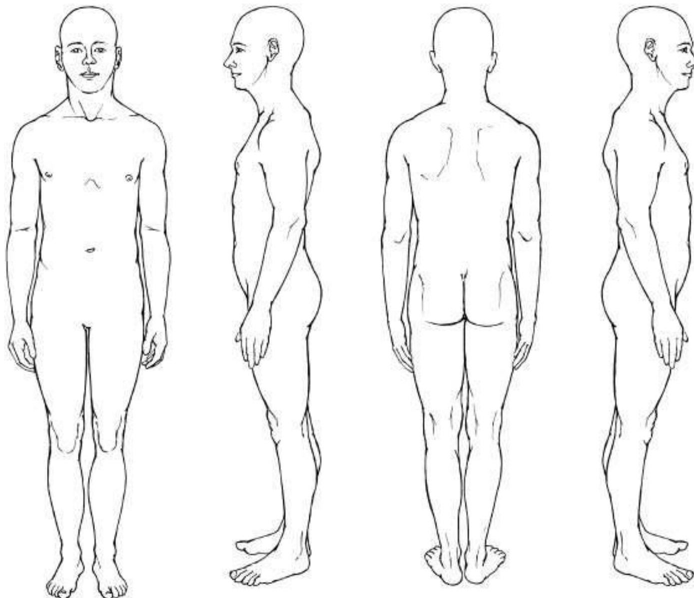
Allergies/Hypersensitivities______________________________

Family History of ______________________________

Major Accidents (include dates) ______________________

Other Serious Medical Conditions ______________________________

Please indicate areas you would like me to focus on and your primary area of complaint.



What is your primary complaint?

______________________________

______________________________

______________________________

______________________________

## Health History and Entrance Form (please check all that apply to you)

**General Symptoms**
- ☐ Fainting / Dizziness
- ☐ Difficulty Sleeping / Fatigue
- ☐ Stress
- ☐ Headaches / Migraines
- ☐ Nervousness
- ☐ Numbness / Tingling; Where: ____________
- ☐ Paralysis

**Skin**
- ☐ Rashes
- ☐ Excessive Dryness
- ☐ Acne
- ☐ Psoriasis
- ☐ Eczema
- ☐ Skin Cancer
- ☐ Bruise Easily

**Infections**
- ☐ Hepatitis
- ☐ Tuberculosis
- ☐ HIV / AIDS
- ☐ Herpes
- ☐ Athlete's Foot
- ☐ Warts

**Respiratory**
- ☐ Chronic Cough
- ☐ Bronchitis
- ☐ Asthma
- ☐ Shortness of Breath
- ☐ Emphysema
- ☐ Family History of ______________________

**Joint / Muscle Discomfort**
- ☐ Jaw
- ☐ Neck
- ☐ Shoulders
- ☐ Arms
- ☐ Hands
- ☐ Upper Back
- ☐ Mid Back
- ☐ Low Back
- ☐ Hips
- ☐ Legs
- ☐ Knees
- ☐ Feet
- ☐ Bursitis
- ☐ Arthritis
- ☐ Family History of Arthritis

**Do You Have / Had?**
- ☐ Diabetes Onset ______________________
- ☐ Cancer; Where ______________________
- ☐ Epilepsy
- ☐ Aneurysm / Stroke
- ☐ Neuromuscular Conditions
- ☐ Hypo / Hyper Glycaemic
- ☐ Depression
- ☐ Multiple Sclerosis
- ☐ Thyroid Problems
- ☐ Fibromyalgia
- ☐ Osteoporosis
- ☐ Mental Illness
- ☐ Artificial Implants / Pins / Plates; Where ______________________________

Male / Female
- ☐ Prostate
- ☐ Pregnant; Due Date ___________________
- ☐ Menstrual Cramping
- ☐ Menstrual Irregularity
- ☐ Birth Control
- ☐ Vaginal Pain / Infections
- ☐ Breast Pain / Lumps
- ☐ Menopausal

**Cardiovascular**
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Heart Attack / Disease
- ☐ Congestive Heart Failure
- ☐ Stroke / Aneurysm
- ☐ Heart Murmur
- ☐ Pacemaker
- ☐ High Cholesterol
- ☐ Swelling of Ankles
- ☐ Cold Hands / Feet
- ☐ Poor Circulation
- ☐ Feet
- ☐ Varicose Veins / Phlebitis
- ☐ Family History of ______________________

**Gastrointestinal**
- ☐ Poor / Excessive Appetite
- ☐ Excessive Thirst
- ☐ Gas / Bloating
- ☐ Colitis
- ☐ Crohn's
- ☐ Constipation
- ☐ Diarrhea
- ☐ Nausea / Vomiting
- ☐ Ulcer
- ☐ Abdominal Cramps
- ☐ Gall Bladder Problems
- ☐ Liver Problems

**EENT**
- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Ear Aches
- ☐ Hearing Difficulty
- ☐ Hearing Aid
- ☐ Stuffed Nose / Sinus
- ☐ Allergies / Hypersensitivity to ____________
  Type of Reaction______________________
- ☐ Swollen Glands

Please read and sign:

- I attest that the information I have provided is true and complete to the best of my knowledge.
- I understand the information I have provided on this form is confidential and will not be released without my written consent.
- I understand that RMT Jorge Tasse can end treatment at anytime due to inappropriate behavior.
- I consent to a health assessment/reassessments and therapeutic massage treatment with RMT Jorge Tasse.
- I authorize RMT Jorge Tasse to contact my doctor or other listed health care professionals, if required for treatment purposes.
- I understand that all sessions include a pre-health assessment and change time.

I understand that 24 hours notice is required to cancel or reschedule appointments, or charges will apply

Signature____________________________________________________ Today's Date ________________________